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STATE OF INDIANA

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STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

County of Lake

2000 043431

2000 JUN 21 AM 9:49
SURVIVORSHIP AFFIDAVIT

MORRIS W. CARTER
RECORDS

Charlene L. Lawson, Successor Trustee of the Lester Lawson and Charlene E. Lawson Revocable Living Trust U/T/A dated November 14, 1994, of full legal age, being first duly sworn upon his/her oath, deposes and says:

Chicago Title Insurance Company

1. That he/she is the daughter of the decedents who were Trustees of the Lester Lawson and Charlene E. Lawson Revocable Living Trust U/T/A dated November 14, 1994, owner in fee simple of the following described Real Estate located in Lake County, Indiana:

Parcel 1: Part of the Southwest Quarter of the Southwest Quarter of Section 30, Township 34 North, Range 7 West of the 2nd Principal Meridian, described as follows: Beginning at a point on the South line of said Section which is 936 feet East of the Southwest corner thereof; thence North at right angles to said South line a distance of 223.56 feet to a point on the Southerly right of way line of State Highway No. 53; thence Southeasterly along said Southerly right of way a distance of 212.19 feet to a point which is 180.74 feet measured along said Southerly right of way line from the point of intersection of said Southerly right of way line and the South line of said Section; thence South 103.47 feet to a point on the South line of said Section which is 148.20 feet West of the point of intersection of said South line and the Southerly right of way of said State Highway No. 53; thence West along said South Section line 174 feet to the place of beginning in Lake County, Indiana.

Parcel 2: Part of the Northwest Quarter of Section 31, Township 34 North, Range 7 West of the Second Principal Meridian, described as follows: Beginning at the Northwest corner of said Section; thence South 89 degrees 17 minutes 57 seconds East along the North line of said Section, 1,102.86 feet to the Northwest corner of a tract conveyed to Ruth Bacon by Warranty Deed dated December 31, 1942 and recorded February 16, 1943 in Deed Record 672, page 584 being 153.50 feet West of the Southwesterly line of State Highway No. 53; thence South 0 degrees 29 minutes 28 seconds West a distance of 569.40 feet to a point; thence North 88 degrees 56 minutes 14 seconds West, a distance of 200.00 feet to a point; thence in a Northwesterly direction 1,023 feet (more or less) to a point on the West line of said Section, said point being 90.00 feet South of the Northwest corner thereof, and said line being all on the North side of the lateral of Stoney Run Ditch; thence North 0 degrees 23 minutes 13 seconds East along said West line 90.00 feet to the place of beginning.

2. Lester Lawson, decedent, died on September 17, 1999, and Charlene E. Lawson, decedent, died on March 28, 1997, both leaving a will, and:

3. The marital relationship, which existed between Lester Lawson, husband, and Charlene E. Lawson, wife, remained continuously and unbroken from the time they acquired title of said Real Estate until Charlene E. Lawson's death.

4. The total value of Lester Lawson's and Charlene E. Lawson's, decedent's estate, taking into consideration in the evaluation thereof, the value of all his/her gifts in contemplation of death, including all gifts to the three (3) years next preceding his/her death, together with the value of all his/her investments and estates by entireties, including the Real Estate above described, plus the proceeds of all insurance on his/her life, did not equal or exceed the sum subject to Federal Estate Tax. All funeral expenses, debts of the estate and inheritance tax have been paid.

5. Affiant makes this affidavit for the sole purpose of clarifying the title to the above described real estate and to induce the Auditor of Lake County to correct the records to show that title is in the name of Charlene L. Lawson, Successor Trustee of the Lester Lawson and Charlene E. Lawson Revocable Living Trust U/T/A dated November 14, 1994, and to induce CHICAGO TITLE INSURANCE CO. to provide title insurance for the above described Real Estate.

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Further Affiant saith not.

Charlene L. Lawson Successor Trustee

Charlene E. Lawson, Successor Trustee of the
Ester Lawson and Charlene E. Lawson Revocable Living Trust dated November 14, 1994
STATE OF INDIANA, COUNTY OF LAKE SS:

Subscribed and sworn to before me, a Notary Public on this 17th day of June, 2000.

Stacey Eisenhutt Stacey Eisenhutt
Notary Public

My Commission Expires: January 15, 2008
County of Residence: Lake

This document prepared by: Charlene L. Lawson



* ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to pursue its statutory responsibility. Disclosure is voluntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

Local No. 2-136-99

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-10-3

43721
TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First, Middle, Last) LESTER L. LAWSON				2 SEX MALE		3a TIME OF DEATH 10:45 PM		3b DATE OF DEATH (Month, Day, Yr) SEPTEMBER 17, 1999	
4 SOCIAL SECURITY NUMBER 305-30-4556		5a AGE—Last Birthday (Years) 70		5b UNDER 1 YEAR Months Days		5c UNDER 1 DAY Hours Minutes		6 DATE OF BIRTH (Mo, Day, Yr) JANUARY 21, 1929	
7 BIRTHPLACE (City and State or Foreign Country) BEAVERVILLE, ILLINOIS		8a WAS DECEDENT A U.S. VETERAN? NO		8b YEAR LAST SERVED IN U.S. ARMED FORCES? ---		8c PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence			
9a FACILITY NAME (If not mentioned, give street and number) 9111 E. 137TH AVE.				9c CITY, TOWN OR LOCATION OF DEATH HEBRON		9d COUNTY OF DEATH LAKE			
10 MARITAL STATUS (Specify) WIDOWED		11 SURVIVING SPOUSE (If wife, give maiden name) NONE		12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) OWNER SELF EMPLOYED			12b KIND OF BUSINESS/INDUSTRY AUTO SALVAGE		
13a RESIDENCE—STATE INDIANA		13b COUNTY LAKE		13c CITY, TOWN OR LOCATION HEBRON		13d STREET AND NUMBER 9111 E. 137TH AVE.			
13e ZIP CODE 46341		13f INSIDE CITY LIMITS <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		14 CITIZEN OF WHAT COUNTRY? USA		15 WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)		16 RACE—American Indian, Black, White, etc. (Specify) WHITE	
17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (10-12) 8 College (1-4 or 5+)		18 FATHER'S NAME (First, Middle, Last) ERVIN LAWSON				19 MOTHER'S NAME (First, Middle, Maiden Surname) LAURA NAESE			
20a INFORMANT'S NAME (Type/Print) CHARLENE LAWSON				20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12683 GIBSON ST. CROWN POINT, IN. 46307				20c Relationship DAUGHTER	
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) SEPTEMBER 20, 1999 SALEM CEMETERY			21c LOCATION—City or Town, State HEBRON, INDIANA			
22a EMBALMER'S NAME THOMAS PRUZIN			22b EMBALMER'S LICENSE NO. 1009893			23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a SIGNATURE OF FUNERAL DIRECTOR 			24b LICENSE NUMBER (of Licensee) 1009893			25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME PRUZIN & LITTLE FUNERAL SERVICE #8300126 811 E. FRANCISCAN DR., CROWN POINT, IN 46307			
26 PART I Enter the diseases, injuries, or complications that caused the death. Do not enter nonspecific terms such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Colon Cancer IMMEDIATE CAUSE OF DEATH: Colon Cancer HEALTH DEPT. SEP 21 1999 CERTIFIES THE ABOVE IS A TRUE AND CORRECT COPY OF THE CERTIFICATE OF DEATH TO BE FILED WITH THE LAKE COUNTY HEALTH DEPT. Conditions, if any, which gave rise to the immediate cause stating the underlying cause last: SEP 21 1999									
PART II Other significant conditions (including contributing to death but not previously stated in Part I) Cholelithiasis, Gallstones, M.D. LAKE COUNTY HEALTH COMMISSIONER			27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) NO			28a WAS AN AUTOPSY PERFORMED? (Yes or no) NO		28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) ---	
29a CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place and due to the cause(s) as stated. <input type="checkbox"/> HEALTH OFFICER On the basis of examination and/or investigation in my opinion, death occurred at the time, date, and place, and due to the cause(s) as stated. <input type="checkbox"/> CORONER On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.									
29b SIGNATURE AND TITLE OF CERTIFIER B. S. Dray						29c MEDICAL LICENSE NO. 01031484		29d DATE SIGNED (Month, Day, Year) September 20, 1999	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28) (Type/Print) RAY E. DRASGA MD 8127 MERRILLVILLE RD. MERRILLVILLE, IN. 46410									
31 HEALTH OFFICER'S SIGNATURE Alexander S. Williams MD							32 DATE FILED (Month, Day, Year) September 21, 1999		
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide			34a DATE OF INJURY (Month, Day, Year)		34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no)	34d DESCRIBE HOW INJURY OCCURRED		
34e PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify)			34f LOCATION (Street and Number or Rural Route Number, City or Town, State)						
34g DATE PRONOUNCED DEAD (Month, Day, Year)			34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc.						

* ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to pursue its statutory responsibility. Disclosure is voluntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

15 N. Franklin St. STE 21
Vaporarisco, IN 46383

CERTIFICATE OF DEATH

State No.

Local No. 0714-91

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-10-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First, Middle, Last) CHARLENE E. LAWSON		2 SEX Female	3a TIME OF DEATH 9:00 P M	3b DATE OF DEATH (Month, Day, Yr) March 28, 1997
4 *SOCIAL SECURITY NUMBER 304-40-2990	5a AGE—Last Birthday (Years) 58	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr) August 15, 1938
7 BIRTHPLACE (City and State or Foreign Country) San Jose, California		8a PLACE OF DEATH (Check only one. See instructions)		
8a WAS DECEDENT A U.S. VETERAN? No	8b YEAR LAST SERVED IN U.S. ARMED FORCES? ---	HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		
9a FACILITY NAME (If not institution, give street and number) 9111 East 137th Avenue		9b CITY, TOWN OR LOCATION OF DEATH Hebron	9d COUNTY OF DEATH Lake	
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife, give maiden name) Lester L. Lawson	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Self-Employed	12b KIND OF BUSINESS/INDUSTRY Ceramics	
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN OR LOCATION Hebron	13d STREET AND NUMBER 9111 East 137th Avenue	
13a ZIP CODE 46341	13f INSIDE CITY LIMITS <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? U.S.A.	15 WAS DECEDENT OF HISPANIC ORIGIN? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16 RACE—American Indian, Black, White, etc. (Specify) White
17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5 +)		18 FATHER'S NAME (First, Middle, Last) Lawrence Smith		
19 MOTHER'S NAME (First, Middle, Maiden Surname) Elvi Toivonen		20a INFORMANT'S NAME (Type/Print) Lester L. Lawson		
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9111 E. 137th Ave., Hebron, IN 46341		20c Relationship Husband		
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) April 1, 1997 Salem Cemetery		21c LOCATION—City or Town, State Hebron, Indiana
22a EMBALMER'S NAME Thomas G. Pruzin		22b EMBALMER'S LICENSE NO. 1009893	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <i>Thomas G. Pruzin</i>		24b LICENSE NUMBER (of Licensee) 1009893	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME PRUZIN & LITTLE FUNERAL SERVICE #3001261 811 E Franciscan Dr, Crown Point, IN 46307	
28 PART I Enter the disease, injuries, or complications that caused the death. Do not enter nonspecific terms, such as cardiac or respiratory failure. Enter the immediate cause of death on one line. Enter the underlying cause of death on another line. Enter the proximate cause of death on a third line. Enter the contributing cause of death on a fourth line. Enter the remote cause of death on a fifth line. Enter the cause of death resulting in death on a sixth line.				Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (First line) Heart failure				
DUE TO (OR AS A CONSEQUENCE OF) Coronary artery disease				
DUE TO (OR AS A CONSEQUENCE OF)				
DUE TO (OR AS A CONSEQUENCE OF)				
DUE TO (OR AS A CONSEQUENCE OF)				
PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I LAKE COUNTY HEALTH COMMISSIONER				
29a CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place and due to the cause(s) as stated. <input type="checkbox"/> HEALTH OFFICER On the basis of examination and investigation, death occurred at the time, date, and place and due to the cause(s) as stated. <input type="checkbox"/> CORONER On the basis of examination and investigation, death occurred at the time, date, and place and due to the cause(s) and manner as stated.		29b MEDICAL LICENSE NO. 01025644		29c DATE SIGNED (Month, Day, Year) 4-3-97
29b SIGNATURE AND TITLE OF CERTIFIER <i>Sam Orlich</i> SAM ORLICH AUDITOR LAKE COUNTY		30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 28) (Type/Print) Kosin Thupvong, M.D., 8687 Corner Court, Merrillville, IN 46410 (219) 769-7800		
31 HEALTH OFFICER'S SIGNATURE <i>Alexander Thupvong, MD</i>		32 DATE FILED (Month, Day, Year) April 3, 1997		
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be Determined		34a DATE OF INJURY (Month, Day, Year)	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no)
34d DESCRIBE HOW INJURY OCCURRED		34e PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify)		
34f LOCATION (Street and Number or Rural Route Number, City or Town, State)				
34g DATE PRONOUNCED DEAD (Month, Day, Year)		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc. 001112 900 KM		

11/11/23